Anchorage Neurosurgical
ASSOCIATES INC.
BRAIN | SPINE | NERVES | EST. 1981

ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

Welcome and Thank You for choosing ANA! Please complete this form. All information will be strictly confidential.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: ☐ F ☐ M Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Ok to Leave Message? Alternate Phone: _____ ☐ Ok to Leave Message?

Patient's Employer: _____ Occupation: _____

Spouse/Parent's Name _____ Date of Birth: _____ Social Security Number: _____

If patient is a minor, who may authorize treatment?
Name: _____ Relationship: _____ Phone # _____

Do you have Medical Insurance?

☐ Yes (Please complete the Insurance Section) ☐ No, I intend to be Self Pay. ☐ Workers Compensation
Is this related to a motor vehicle accident or any other third party liability claim? ☐ YES ☐ NO

Primary Insurance	Secondary Insurance	Tertiary Insurance
I.D. # or Social Security #	I.D. # or Social Security #	I.D. # or Social Security #
Group Number	Group Number	Group Number
Insured Person and Date of Birth	Insured Person and Date of Birth	Insured Person and Date of Birth

Insurance Authorization and Assignment- Initial Below for Each

_____ I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to ANCHORAGE NEUROSURGICAL ASSOCIATES, INC. for services furnished to me by that facility and the affiliated physician(s).

_____ I authorize this office to release and disclosure to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ I have received a copy of Anchorage Neurosurgical Associates, Inc.'s Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ I have received a copy of Anchorage Neurosurgical Associates, Inc.'s Notice of Electronic Communications and authorize this office to communicate with me by email or text message.

Email: _____
Phone Text: _____

_____ _____
Signature of Patient, Guardian, Person or Legal Representative Date

*****PLEASE TURN OVER THIS FORM AND COMPLETE THE OTHER SIDE!*****

Revised 9-7-22

Patient Name: ____________________

Primary Medical Health Care Provider (First and Last Name): ____________________

Would you like a copy of your chart notes from today to be sent to them for their records? ☐ YES ☐ NO

Other Health Care Providers: Would you like them to receive your chart notes? ☐ YES ☐ NO

____

____

Do you have any forms with you today that will need to be completed? ☐ YES ☐ NO

Do you have a Nurse Case Manager to assist with your care? ☐ YES ☐ NO

Person(s) to Contact in Case of an Emergency

Name: ____________________ Relationship: ____________________

Phone 1: ____________________ Phone 2: ____________________

ANAI may discuss my medical info with this person: ☐ ANAI may discuss my billing info with this person: ☐

This person may pick up my prescriptions from ANAI: ☐ This person may pick up my records, forms or information: ☐

Name: ____________________ Relationship: ____________________

Phone 1: ____________________ Phone 2: ____________________

ANAI may discuss my medical info with this person: ☐ ANAI may discuss my billing info with this person: ☐

This person may pick up my prescriptions from ANAI: ☐ This person may pick up my records, forms or information: ☐

Name: ____________________ Relationship: ____________________

Phone 1: ____________________ Phone 2: ____________________

ANAI may discuss my medical info with this person: ☐ ANAI may discuss my billing info with this person: ☐

This person may pick up my prescriptions from ANAI: ☐ This person may pick up my records, forms or information: ☐

I acknowledge that Anchorage Neurosurgical Associates, Inc may provide my medical information as noted to the person(s) I have designated above.

____________________ ____________________

Signature of Patient, Parent, Guardian, Personal or Legal Representative Date